|  |
| --- |
| **Assistive Technology Assessment Form** |
| **Child Demographics**  |
| **Child Name** | **Date of Birth** | **Assessment Date** | **Diagnosis Code (ICD-10)** | **Insurance Information** |
|  |  |  |  |  |
|  |
| **Assistive Technology Assessment Team Members** |
| **Provider Name** | **Provider Code** | **Provider Type** | **Medicaid ID** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |
| **Reason for Assistive Technology is being recommended:** |
|  |
| **Child’s goals and outcomes that will be addressed with this technology:** *(Please include the child’s IFSP outcome and date of the IFSP)* |
|  |
| **How will assistive technology increase, maintain, or improve the child’s functional capabilities?** |
|  |
| **Other funding sources (To be completed by the SC)** |
|  |
| **Please describe the training plan for the parents and caregivers:** |
|  |
| **Assessor Name** | **Signature** | **Date** |
|  |  |  |
| **Service Coordinator** | **Signature** | **Date** |
|  |  |  |